SOCIAL CLASS DIFFERENCES IN ATTITUDES TOWARD PSYCHIATRY*,[1]

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IN A series of recent studies exploring social structure and psychiatric disorders, a significant relationship between social class and prevalence of treated psychiatric disorders was established. We were particularly impressed with the more frequent prevalence of treated psychoneuroses in the higher social classes and of chronic schizophrenia in lower classes (5, 12, 13). An important finding was the fact that patients of higher classes (classes I and II) more frequently receive psychotherapy, particularly so-called insight therapy, than lower classes (classes IV and V), who are more likely to receive supportive psychotherapy, organic treatment, or no therapy (12). A study in a psychiatric dispensary, where ability of the patient to pay was a controlled factor, demonstrated that social status is closely related to 1) acceptance for therapy, 2) length of therapy, 3) duration of therapy sessions, and 4) choice of therapist (8, 15).

With these facts in mind, we asked ourselves whether or not social class influenced the attitudes of neurotic patients to psychiatric therapy and whether or not it influenced the therapists' attitudes and the course of therapy. The importance of such an exploration was previously stressed by Redlich (11). The following report deals with the investigation of attitudes in relation to social class.

Only a few studies have been made of the relationship between social class and level of information about psychiatry and of the relationship between social class and attitudes toward mental illness and psychiatric treatment. An analysis by Redlich reports the responses of small lay groups to a sentence-completion test and to a multiple-choice type of questionnaire about mental health. He noted a possible class difference in information level. This paper also contains a bibliography of earlier publications (10). A study by Hollingshead surveyed a representative sample of newly married couples in New Haven, using an interview approach. A decided class difference in willingness to utilize psychiatric help for marriage difficulties and a class difference in respondents' familiarity with psychiatry were apparent (4). Class differences in attitudes have also been emphasized by Dollard and Miller, who assert the existence of different attitudes to homosexuality and

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other psychopathological phenomena in the different classes (2).

The various polling surveys have noted a relationship between educational level and attitudes toward psychiatry. The better-educated respondents are "more humanitarian" and "more scientific" in their ideas about mental illness and treatment than are those with less education (3, 16). These surveys, however, deal chiefly with responses people say they would make in hypothetical situations. Questions which tap present attitudes are more likely to yield responses indicating a certain amount of prejudice and lack of understanding about mental illness even among those who are supposedly well informed and who are in the higher social levels, for instance, among specialized panels of lawyers, clergymen and teachers. Over a third of the medical men showed similar prejudices (14). In an analysis of cartoons about psychiatrists, Redlich concluded that persons in the higher social levels show fear and hostility toward the psychiatrist at both the conscious and unconscious level (9).

In sum, large segments of the public are uninformed about various aspects of mental illness and treatment. Although the better-educated and those in higher social levels seem better informed than the general public, they also reveal areas of prejudice and misunderstanding about some aspects of psychiatry.

Method

Following Hovland, Janis, and Kelly (6), we use the term "attitude" to designate an intervening variable inferred primarily from action responses to situational stimuli. The action responses are participation in psychiatric treatment; they are responses to various stimuli, such as behavior, situations, thoughts, affects and fantasies around psychiatric illness and treatment. We infer attitudes wherever we can from a real situation and not from a hypothetical question. We wish to stresss, too, that in this report we are almost exclusively concerned with overt verbal and nonverbal behavior and make only cautious and occasional reference to unconscious attitudes, simply because our material does not permit such inference.

We attempted to explore: 1) Attitudes of neurotic patients inferred from the nature of the chief presenting complaint. 2) Attitudes of neurotic patients inferred from source and method of referral of patients to psychiatrists. 3) Attitudes of neurotic patients inferred from knowledge prior to contact with psychiatrists and changes of such knowledge during contact with psychiatrists. 4) Attitudes inferred from sentiments expressed by neurotic patients at first contact with psychiatrists. 5) Attitudes inferred from the nature of communication between neurotic patients and their therapists during treatment. 6) Attitudes of therapists to neurotic patients.

Our data were collected from 50 psychiatric patients, who were selected

according to the requirements of a stratified sample on the basis of the following criteria: 1) sex, 2) age, 3) diagnosis, and 4) social class position. We selected 25 males and 25 females between 22 and 44 years of age who had been diagnosed as psychoneurotic or schizophrenic and who were from classes III and V. Patients were chosen from nonadjacent classes because we were interested in attempting to assess the influence of class position on various aspects of mental illness. We focused upon classes III and V for three reasons: they represent 40 per cent of the population of the New Haven community; they have different rates for "treated prevalence"; these classes have not been studied carefully in previous psychiatric research.

Social class was determined by Hollingshead's *Index of Social Position.* This index utilizes three factors: occupation, education, and ecological area of residence, from which, after appropriate statistical analyses, each individual can be assigned to one of five social classes. Class I stands at the top of the socioeconomic scale, class V at the bottom. Occupationally, class III is composed, in large part, of proprietors of small businesses, white-collar workers, and skilled manual workers. Educationally, it consists predominantly of high-school graduates. Residentially, these people live in flats and single family dwellings in widely scattered areas. The composition of class V is almost exclusively unskilled and semiskilled workers who have an elementary education or less and who live in the most crowded areas of the New Haven community.

Patients with known psychosomatic complications were excluded from the sample. Additional qualifications for inclusion in the survey were: 1) the patient had to be willing to enter the study; 2) members of his family had to be willing to cooperate; and 3) his therapist had to consent to have the patient studied. The sample was drawn largely—by reason of class status— from clinics, state and VA hospitals. The 50 cases were gathered over a year and a half so that patients were at various stages of treatment during the interviewing. Each patient was interviewed at least three times by two different psychiatrists. The sociologists interviewed the families, including a spouse, sibling, and at least one parent. The therapist in charge of each case was interviewed also by a psychiatrist on the project. Following completion of this field work, two separate teams composed of a sociologist and a psychiatrist evaluated each case. After we completed the field work on all the cases, we found, by statistical analysis, that our sample was representative of neurotic and schizophrenic patients in our census study who were between the ages of 22 and 44 and who were in classes III and V.

The tables and the examples in this paper are derived chiefly from direct statements by the patient and therapist. Many of the ratings were made by more than one judge; the agreement varied but was always high. We have not attempted to deal with preconscious or unconscious attitudes. In this

particular paper, we make use primarily of material obtained from the 25 neurotic patients, although we do refer to our previously reported census study.

Findings

Attitudes inferred from chief complaint of neurotic patients. Our neurotic patients presented a great variety of complaints at their first psychiatric interview. We divided these into somatic complaints and emotional and interpersonal complaints. Emotional and interpersonal complaints could not be clearly differentiated. In most of our patients the two types of complaints coexisted. Thus, we had to make judgments as to definite predominance of one of the types of responses. Findings are presented in Table 1.

It would seem that class III patients present their complaints in terms of emotional and interpersonal difficulties more frequently than class V patients, who usually present themselves with "somatic" symptoms. Scrutinizing our records, we were impressed with the fact that prior to any contact with psychiatry, many patients in both classes considered their difficulties as an expression of organic illness. Patients expressed their organic bias during therapy by asking their therapists for "pills" and "shots" and expressing their lack of confidence in a "talking" treatment. Class III patients, as will be demonstrated later, seem more inclined than class V patients to acept the notion of psychogenic etiology in the course of treatment.

Attitudes of patients inferred from source and method of referral. From our psychiatric census study, we noted that neurotic patients in both classes showed a high frequency of referral by physicians. Class III patients were usually referred by general practitioners in the community whereas class V patients were referred by the staff of a medical dispensary or of an emergency room. Social agencies played a larger role in the referral of class V patients, and a considerable number of class V neurotics were committed. Self-referrals in class V were absent, but 20 per cent of our class III patients came to treatment on their own initiative.

Attitudes of patients inferred from knowledge prior to contact with psychiatrists and changes of knowledge. In general, knowledge about psychiatry on

TABLE 1. PREDOMINANT TYPE OF PRESENTING COMPLAINT BY CLASS

Type of Complaint	*Class III*	*Class V*
Somatic	2	9
Emotional and interpersonal	11	3
Total	13	12

$\chi^2 = 6.74$; $p < .01$

TABLE 2. LEVEL OF PSYCHIATRIC KNOWLEDGE OF NEUROTIC PATIENTS BEFORE TREATMENT

Class	*Fair*	*Poor*	*None*
III	5	2	6
V	—	—	12
	—	—	—
Total	5	2	18

$\chi^2 = 6.5021$; $p < .02$

the part of all our patients was quite inadequate. Our ratings were based on molar judgments, using three categories: fair, poor, and none. In making such ratings we relied on direct statements by neurotic patients to our investigators, as well as on evaluation of the patients' communications during treatment. See Table 2.

Actually, we found that few patients before entering treatment understood any of the principles of dynamic psychiatry, and even those patients whose knowledge we rated as fair usually knew little more than that psychiatry deals with mental illness, that psychiatrists heal their patients not only by medicine or surgery but also by "mental" methods. During psychotherapy, some of our patients learned something about the "human mind," about unconscious conflict, about mental mechanisms expressing themselves in psychological and somatic symptoms, and how obtaining and applying insight to their problems can help. Again, we found a definite, though not a statistically significant, class difference among those who gained in knowledge and those who did not. See Table 3.

Attitudes inferred from sentiments by neurotic patients upon entering therapy. Most of our patients were averse to the idea of psychiatric intervention. We were not able to measure or rate differences in hostility and anxiety expressed by class III and class V patients. In many instances, hostility was rooted in fear and shame, as illustrated by such typical comments as, "People think you are crazy when you come to see a psychiatrist" or "Psy-

TABLE 3. INCREASE IN INFORMATION OF NEUROTIC PATIENTS DURING TREATMENT

Class	*Moderate*	*Slight*	*No Increase*
III	3	4	6
V	—	2	10
	—	—	—
Total	3	6	16

$\chi^2 = 2.3040$; $p < .20$

chiatry is fine for crazy people but it can't help me." It was difficult for all our patients to accept the idea of exploring their own emotions. Even among those who seemed most willing to talk about their problems, a number were apparently complying in the hope that after the "talking" would come the "treatment." In some of these patients this hurdle was never overcome and therapy came to a standstill.

Most of the neurotic patients started treatment rather passively. Even after they were in treatment, with the exception of the few who "got the idea," patients remained hesitant and unable to utilize psychiatric help. They tended to retain their rigid attitude and considered the psychiatrist as a magical doctor who could miraculously cure their physical ills; they expected "pills and needles," sympathy and warmth, and they were disappointed at not having such demands gratified. Even when therapists decided to change from insight therapy to supportive treatment, their patients tended to be disappointed in not getting sufficient practical advice about how to solve their problems and how to run their lives. Table 4 indicates that such inability to change was more apparent in class V patients than in class III patients.

Communication between therapists and neurotic patients by class. We attempted to make a molar rating of communication between therapists and patients (Table 5). Such a rating, using categories of "good," "intermediate," and "poor" after psychotherapy was under way, was based on whether or not therapists and patients were relating meaningfully to each other on the verbal level and whether or not the patient understood the principal intent of the therapist. Many of our patients, particularly those in class V, neither understood nor accepted the notion that psychological conflict may reveal itself in physical symptoms. In one of our class V cases, the therapist thought that after six months of "insight therapy," the patient accepted the idea that his troubles were not caused by his "bad teeth" but by his unresolved anxieties and frustrations. When our investigators interviewed the patient some time later, he still clung to the "theory" that his teeth had poisoned his system and made him weak. If the therapeutic intent was

TABLE 4. CHANGE OF ATTITUDE DURING TREATMENT BY NEUROTIC PATIENTS BY CLASS

Class	*No Change*	*Change*
III	2	11
V	8	4
Total	10	15

$\chi^2=4.86$; $p<.05$

TABLE 5. LEVEL OF COMMUNICATION BETWEEN THERAPIST AND NEUROTIC PATIENT BY CLASS

Level of Communication	*Class III*	*Class V*
Good	4	—
Intermediate	3	—
Poor	6	12
Total	13	12

$\chi^2 = 6.50$; $p < .02$

treatment through insight, it was not grasped by any of our lower class V patients, nor by approximately half of the class III patients. For instance one patient said about "insight therapy," "The doctor teaches me to forget things in my past." "Talking therapy" struck some patients as "silly and ridiculous" or, as one said, "Talking about my troubles makes me feel worse."

Attitudes of therapists to neurotic patients by class. In considering whether attitudes toward mental illness and psychiatric treatment affect the process of diagnosis and therapy, the attitudes of the therapist toward his patients must be taken into account. We interviewed 17 therapists: 3 private practitioners, 9 residents, 2 medical students, and 3 psychologists, who were rather evenly distributed by social class of their patients. By direct interview and by scrutinizing the records, we tried to assess judgments of therapists about their patients—whether they held views and values similar to those of their patients, whether they noticed social differences between themselves and their patients, whether they would cultivate them as friends, whether generally they liked or disliked the patients. Our rating of such "surface" attitudes is expressed in Table 6. The numerical differences by

TABLE 6. THERAPISTS' ATTITUDES TOWARD NEUROTIC PATIENTS BY CLASS

Therapist's Attitude	*Class of Patient*	
	III	V
	# %	# %
"Liked" patient	9 (61.5%)	2 (16.6%)
"Disliked" patient	3 (23.1)	9 (50.0)
Intermediate or unclear	1 (15.4)	1 (33.3)
Total	13 (100 %)	12 (99.9%)

$\chi^2 = 4.66$; $p < .05$

class in such a gross rating are striking. Much of the "dislike" of these patients, particularly of the lower class patients, is due to the frustration of the therapist who had to work with a "bad case" in which desperate environmental difficulties made therapeutic gains unlikely. In many cases, the value systems pertaining to therapeutic interaction were far apart. In a number of class V patients the therapists disapproved of their sexual and aggressive behavior, their lack of discipline and responsibility. While our therapists often enough rejected class III values they at least understood them; in contrast to this, they were at a loss to understand values of class V patients.

Most of the therapists were strongly motivated to carry out and learn insight therapy and felt disappointed when their plans failed. Moreover, a lack of personal feeling and understanding for the lower class patient was apparent. Therapists were irritated by overwhelming demands or the patient's inability to comprehend therapy. The following are illustrations of such attitudes: "Seeing him every morning was a chore; I had to put him on my back and carry him for an hour"; or, "He had to get affection in large doses; this was hard to do"; or, "The patient was not interesting or attractive; I had to repeat, repeat, repeat"; or, "She was a poor, unhappy, miserable woman—we are worlds apart." Most of the male therapists were somewhat more tolerant of female patients than of male patients in the same class.

Discussion

Like other investigators, we were impressed with the widespread fear of mental illness, hostility toward psychiatrists, and ignorance of the subject matter of psychiatry. Certainly, fear and reluctance, whether openly expressed or inferred from preconscious or unconscious fantasies, such as demonstrated in the paper on the psychiatrist in caricature (9), are not limited by class.

In our controlled case study, the differences in attitudes of class III and class V patients were definite but relatively small. However, the social status differences in our patients were small, too, as some of our class III patients actually came from class IV families. We know that social mobility is an important factor influencing attitudes toward psychiatry, particularly if attitudes are inferred from empathy and communication between psychiatrist and patient. This aspect of the problem will be treated in detail in another paper.

From experiences with class I and class II patients, not cited in our findings, we know that conscious attitudes toward psychiatry are more favorable in these classes and that knowledge of modern psychiatric principles is more substantial among such patients. The essential values underlying insight therapy are more likely to be shared by psychiatrists and upper class

patients. Good therapy takes a good therapist, and at this stage of our knowledge also a good patient capable of some empathy with his psychiatrist. Such patients, it seems, are more frequently found in the upper classes. As we gain knowledge in psychotherapeutic techniques the patients' empathy will become less and less necessary.

Although the existence of unconscious processes and psychodynamic considerations was difficult for most of our patients to conceive, such notions had the least reality for the class V patient before and during treatment. This is not surprising as class V persons have less formal education and are less rewarded for verbalization and for thinking, particularly for thinking about symbolic and interpersonal processes which are crucial in grasping concepts and methods of dynamic psychiatry. Books and lectures on psychiatry have reached—at least superficially—the upper and middle social classes, but they have not had any impact on class V individuals. The occasional use of movies and modern mass media of communication have had as yet little effect on this population. From our material, it would seem that the Armed Forces are the greatest educators of the lower classes in understanding psychiatry and mental hygiene.

At this time insight therapy is less likely, in our opinion, to be grasped by the lower classes than physical therapy or a therapy employing "magical methods." This should not be construed as a recommendation of "supportive" or "suggestive" techniques but as a challenge to find appropriate methods for all kinds of patients. We are just interested in paving the way for a rational method of emotional re-education for lower class patients. Maxwell Jones (7) has been pioneering in developing such techniques in a hospital setting. What has been said about therapy may be applied to prevention, too. Ideas of prevention, based on the propositions of dynamic psychiatry, and carried out by the Mental Hygiene Movement, have not penetrated to the lower classes. Much education and a search for new and better techniques need to be undertaken before the largest segments of the population can be reached. Kingsley Davis came to similar conclusions (1).

As we stated before, the lack of rapport and communication found between our therapists and patients, particularly class V patients, is partly due to the fact that most of the therapists in our controlled case study were beginners. But, for the most part, these *are* the therapists who will be dealing with class V patients and with many of the class III patients, also. We wish to stress our belief that psychotherapy of class V patients is by no means impossible; but such techniques need to be developed. Psychotherapists who are able to devise therapeutic techniques for children and schizophrenics should be able to do the same for lower class patients. To achieve this, they will have to learn more about the way of life of these patients, their ethnic and social values and attitudes; and they will have to overcome some of

their own social prejudices. Such understanding will be important in arriving at more efficient and rational methods of psychotherapy for lower class patients, who are more in need of help than any other group.

Summary

Patients in class III and class V shared similar outlooks toward mental illness and psychiatric treatment, but some qualitative and quantitative differences in these areas are apparent and seem to be related to social class status.

1. Although patients of both class III and class V had a tendency to conceive of their difficulties as somatic, class V patients were more likely to do so than class III; and class V patients were less likely to correct their somatic biases during treatment.

2. Class V patients were less likely than class III patients to come to treatment on their own initiative and more likely not to change their attitudes toward psychiatry once in treatment.

3. Class V patients knew less about psychiatry than class III patients, as expected, and were less likely to pick up information during the course of treatment.

4. Therapists were superficially aware of social differences between them and both class III and class V patients. With their class V patients, however, they more frequently "disliked" the patients, did not understand their values, and often had difficulty in understanding them as persons. Therapists disliked the class V patients' lack of responsibility and discipline, their dependency and ineptness at facing and correcting their emotional problems. Many of the therapists became discouraged in treating class V patients, especially when extremely difficult reality situations were added to other difficulties.

5. Communication between therapists and many patients of both class III and class V was poor, though this was decidedly more marked with class V patients. These patients were less likely to understand what their therapists were driving at and more likely to accept the therapist's authority than class III patients. They wanted relief from misery but did not comprehend how understanding themselves could have any bearing on their life situations.

6. Practical implications from our findings in terms of more adequate methods of psychotherapy for lower class patients are mentioned.

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